Patient Information (Confidential)

Name_____ Date_____
First Middle Last

Address _____ City_____State_____Zip_____
Cell # _____ Soc. security #_____Birth date_____Home phone_____
Email _____

Check Appropriate Box ☐ Minor ☐ Single ☐Married ☐Divorced ☐Widowed ☐Separated

If college student, F.T./P.T., name of school_____ City_____State_____
Patient's or parent's employer_____ Work phone_____
Business address _____ City_____State_____Zip_____
Spouse or parent's name _____Employer_____Work phone_____
Whom may we thank for referring you _____
Person to contact in case of an emergency _____ Phone_____

Responsible Party

Name of person responsible for this account _____ Relationship to patient_____
Address _____Home Phone_____
Driver's license #_____Birth date_____Soc. security #_____
Employer _____ Work phone_____
Is this person currently a patient in our office ☐ Yes ☐ No

Insurance Information

Name of insured _____ Relationship to patient_____
Birth date_____ Soc. security #_____Date employed_____
Name of employer_____ Union or local #_____Work phone_____
Employer address _____ City_____State_____Zip_____
Insurance co._____ Tel. #_____Grp. #_____Policy/I.D. #_____
Ins. co. address_____ City_____State_____Zip_____
How much is your deductible _____ How much have you used_____Max annual benefit_____

Do you have any additional insurance ☐ Yes ☐ No If yes, complete the following:

Name of insured _____ Relationship to patient_____
Birth date_____ Soc. security #_____Date employed_____
Name of employer_____ Union or local #_____Work phone_____
Employer address _____ City_____State_____Zip_____
Insurance co._____ Tel. #_____Grp. #_____Policy/I.D. #_____
Ins. co. address_____ City_____State_____Zip_____
How much is your deductible _____ How much have you used_____Max annual benefit_____

X_____ _____

Signature of patient or parent if minor **Patient number**